

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
APPLICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM (NEMT)

Section I: TO BE COMPLETED BY APPLICANT.

Note: This must be completed **in ink** and turned in to the local DHHR office **within 60 days of the earliest trip.**

Name: _____ Date(s) of Travel: _____

Street, Route or PO Box Number: _____

City _____ Zip Code _____ County _____

Telephone Number _____ Social Security Number _____

MA ID number from each patient's Medicaid card (this is the 11-digit number to the left of the person's name on the card):

Section II: APPLICANT RESPONSIBILITIES AND SIGNATURE

Please read each statement carefully and check either Yes or No.

1. Yes No I **understand** that I may request a Fair Hearing if I am not satisfied with the decision regarding my application for non-emergency medical transportation payments (NEMT). I may also request a Fair Hearing if I feel that I have been discriminated against because of race, color, national origin, sex, age, religion, or political belief, or because I am disabled. I **further understand** that I may be represented by an attorney at a Fair Hearing, but that neither DHHR nor any of its authorized representatives will pay for the legal services.
2. Yes No I **understand** that I may be asked to verify any or all information on this application form or to provide additional information and that failure to provide this verification or information will result in denial. I **also understand** that alterations on this form must be initialed by me or the application may be denied.
3. Yes No I **understand** that this completed application, including all required verification, must be received by the local DHHR office no later than 60 days from the date of the trip for which I am requesting payment. I **further understand** that if the application or verification is received 61 or more days after the trip, that my application will be denied.
4. Yes No I **understand** that I am to use the least expensive transportation available, taking into consideration my physical condition and the travel locations.
5. Yes No I **understand** that the following expenses must be approved before the trip is taken: lodging, out-of-state transportation, double round trips on the same day and requests for an immediate family member to stay with a patient at a medical facility. Receipts for lodging must be provided with the application.
6. Yes No I **understand** that meals are permitted for the patient and the driver of a private vehicle when overnight lodging is approved. All meals are the responsibility of the patient and driver when an overnight stay has not been approved.

7. Yes No I **understand** that waiting time charges for a taxi may be included for travel from city to city, but not within the city of taxi operation.
8. Yes No I **understand** that neither DHHR nor any of its employees is responsible for any damages from an accident which may occur during the trip for which I am requesting payment.
9. Yes No I **understand** that the Criminal Investigations Unit investigates all allegations of NEMT program abuse and, when warranted, refers such cases for prosecution under WV Code 61-3-24. I also **understand** that criminal penalties may include jail/prison sentences and/or fines. In addition, I **understand** that I may also be required to repay any benefits to which I was not entitled.
10. Yes No I **understand** that my signature means that I have read, or had someone read to me, all statements on this form and that I understand all questions. My signature also **indicates** that these expenses are not reimbursable by anyone else and that all information given is true and correct to the best of my knowledge.

Applicant's Signature _____ Date _____

Section III: VERIFICATION OF TRAVEL AND ATTENDANCE

NOTE: The following section requires signatures from the medical provider or representative and from the driver or other transportation provider. Please fill out in ink and initial any changes or corrections after striking out the information in error. Do not use correction fluid or tape. Additional trips (up to a maximum of 4) may be listed using the DFA-NEMT-1a supplemental form which must be attached to this application.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:

MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine Follow-up Walk-in Initial

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

Signature of Medical Provider or Authorized Representative _____ Date _____

Transportation Provider: Private Vehicle Taxi Bus Plane Community Van Other

Driver's/Carrier's Name (Please print) _____ SSN or Tax ID _____

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage _____ Parking _____ Tolls _____

Common/contract Carrier: Round-trip fare _____

Lodging: Cost per night _____ Number of nights _____

Meals: Number of persons _____ Number of meals per person _____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:

Miles _____ X _____ = _____
Total lodging _____
Other costs _____
Total for this trip _____